



Intercollegiate Basic Accident Medical Insurance Quote Request Form

Name of Institution: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Contact: _____ Title: _____

Email: _____ Phone: _____

| SECTION 1 – COVERED PARTICIPANTS | | | | | |
|---|-----|-------|-----------------------|-----|-------|
| Please Complete the Estimated # of Participants | | | | | |
| Intercollegiate Sport | Men | Women | Intercollegiate Sport | Men | Women |
| Acrobatics & Tumbling | | | Mascots | | |
| Archery | | | Racquetball | | |
| Badminton | | | Riflery | | |
| Band | | | Rodeo | | |
| Baseball | | | Rowing/Crew | | |
| Basketball | | | Rugby | | |
| Beach Volleyball | | | Sailing | | |
| Bowling | | | Skiing | | |
| Boxing | | | Soccer | | |
| Cheer-Competitive | | | Softball | | |
| Cheer-Non-Competitive | | | Squash | | |
| Cross Country | | | Student-Coaches | | |
| Cycling | | | Student-Managers | | |
| Dance | | | Student-Trainers | | |
| Drill Team | | | Swimming/Diving | | |
| Equestrian | | | Tennis | | |
| E-Sports | | | Track & Field | | |
| Fencing | | | Volleyball | | |
| Field Hockey | | | Water Polo | | |
| Football | | | Weightlifting | | |
| Golf | | | Wrestling | | |
| Gymnastics | | | Other: _____ | | |
| Ice Hockey | | | Other: _____ | | |
| Karate/Judo | | | Other: _____ | | |
| Lacrosse | | | Other: _____ | | |
| Total | | | | | |

Basic & Catastrophic Accident Medical Insurance is also available for your Club and Intramural sports. Coverage can be added as a separate class within this policy, or as a separate policy. Please contact BMI for more information and next steps.

SECTION 2 - PREVIOUS POLICY INFORMATION

| Policy Benefits | Current Year | 1 Year Prior | 2 Years Prior | 3 Years Prior | 4 Years Prior |
|-----------------------|--|--|--|--|--|
| Insurance Carrier | | | | | |
| Claim Administrator | | | | | |
| Medical Maximum | | | | | |
| Deductible | | | | | |
| Benefit Period | | | | | |
| AD&D Benefit | | | | | |
| AD&D Aggregate | | | | | |
| Expanded Medical | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HMO/PPO Benefit | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| H&C Benefit | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Re-Injury Benefit | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Guest/Recruit Benefit | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Premium | | | | | |
| Claims Paid | | | | | |
| Paid Through Date | | | | | |

SECTION 3 – ADDITIONAL PROGRAM INFORMATION

Does the Sports Medicine Team utilize an Injury Tracking Software/EMR System? Yes No
 If yes, what system/platform is being use today? _____
 Does the Athletic Department have a primary insurance requirement for athletes? Yes No

SECTION 4 – QUOTE OPTIONS

DEDUCTIBLE – Please select all options you would like quoted:
 \$0 \$250 \$500 \$750 \$1,000 \$2,500 \$5,000 Other: _____
MEDICAL MAXIMUM – Please select all options you would like quoted:
 \$25,000 \$35,000 \$50,000 Other: _____

Please send completed form, including a copy of your current master policy and current valued claim reports to collegesports@bobmccloskey.com or via fax at 732.583.9610 Attn: NCCAA. If you have any questions or need to discuss further, please contact our office at 800.445.3126 and ask for Rob McCloskey.

If your school is working with a broker, please have the below information completed.

LOCAL/REGIONAL INSURANCE AGENCY

Agency Name: _____
 Agent Name: _____ Agent License #: _____
 Email: _____ Phone: _____
 Agency Street Address/City/State/Zip: _____

**Bob McCloskey Insurance | Morganville, NJ 07751
 Phone: 800.445.3126 | www.bobmccloskey.com/nccaa | Fax: 732.583.9610**

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